APPLICATION FOR APPN REINSTATEMENT HOLDS A RN COMPACT LICENSE

PLEASE NOTE

Use this application if:

The APPN license is lapsed
You reside in another Compact State

Criminal Background Checks - Fingerprint cards are required for all applicants.
Cards are available from the Board office. See Item "Fingerprint Card – Related Fees"

REINSTATEMENT APPLICATION INSTRUCTIONS FOR ADVANCED PRACTICE PROFESSIONAL NURSES
NURSE LICENSURE COMPACT STATE RESIDENT

This application may be used by nurses applying for reinstatement of licensure as an advanced practice professional nurse (CNM, CNS, NP, RNA). ***NOTE: If you are applying for advanced practice licensure and are currently licensed as a professional nurse (RN) and are residing in a State that has adopted the Nurse Licensure Compact (Arizona, Arkansas, Delaware, Iowa, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, or Wisconsin), you do not need to apply for an Idaho professional nurse (R.N.) reinstatement in addition to your APPN license.***

The following must be on file with the Board of Nursing in order to determine your eligibility for APPN reinstatement in Idaho. Documents requiring notarization may NOT be received by FAX. (All documents become the property of the Board and may be destroyed, without further notification, if the application is not completed within one year.)

1. **APPLICATION FORM:** Only application forms provided by the Board, completed in ink and notarized will be accepted. Photocopies or faxed copies of application forms will not be accepted.
   1) If all information requested is not supplied, provide an explanation for the omission.
   2) Sign the affidavit with your usual signature and have it notarized.
   3) Attach a 2 x 2 identification photograph, taken within the last year. Electronically scanned photos are not acceptable; features must be clearly identifiable. Black & white or color photos are acceptable.
   4) For any screening questions answered 'yes', attach a written statement of circumstances, including dates, events, outcomes, etc. Providing false or incomplete information on this application may be grounds for denial of licensure.
2. **FEE.** Enclose the appropriate fee for reinstatement:
   Advanced Practice Professional Nurse (CNM, CNS, NP, RNA) - $125.00
   APPN Temporary License (available upon request) – No Fee
3. **RN LICENSE.** Attach a copy of your current RN license in a Compact state to the enclosed affidavit.
4. **ADVANCED PRACTICE PROFESSIONAL NURSE NATIONAL CERTIFICATION**. Attach a copy of your current certificate to the enclosed affidavit.
5. **ATTESTATION.** Carefully read the attestation regarding your APPN practice and initial that you have read this statement. If you are unable to attest that you have practiced the minimum period of time, you may be issued a temporary license in order to acquire the required number of hours and demonstrate ability to safely practice as an advanced practice professional nurse in Idaho.
6. **APPN CONTINUING EDUCATION.** Provide documentation of thirty (30) contact hours of APPN continuing education during the past two (2) year period. Continuing education completed may be that required for renewal of national certification if documentation is submitted confirming the certifying organization's requirement is for at least thirty (30) contact hours. Advanced practice professional nurses applying for reinstatement of prescriptive authorization must also complete ten (10) contact hours of approved pharmacology-related continuing education in the twenty-four months immediately preceding application as part of the required thirty (30) hours.
7. **AFFIDAVIT.** The affidavit on page 2 must be completed and notarized in order for your application to be valid.
8. **FINGERPRINT CARD**. Complete the required Fingerprint card and submit to the Board for processing. Only cards from the Board office are acceptable - **fee for processing - $34.00.**

INSTRUCTIONS FOR TEMPORARY LICENSURE

Advanced practice professional nurse applicants (CNM, CNS, NP, RNA) applying for APPN temporary licensure, who reside in and are currently authorized to practice in a Compact state must submit the completed application form and the "Affidavit Attesting to Validity of Copy", attached to a copy of the current national certification certificate showing the expiration date.

PLEASE BE ADVISED: Advanced Practice Professional Nurses must renew their license(s) by August 31st of every odd-numbered year. A nurse who applies for licensure on or after March 1st of the year, in which the license would ordinarily be renewed, will be issued a license valid until the next renewal period. *5/06*

Idaho Board of Nursing – 280 North 8th Street, Suite 210, Boise, Idaho 83720-0061
Mailing Address: PO Box 83720
Voice – (208)334-3110 – FAX –(208)334-3262 TDD Relay –(800)377-3529

IDAHO BOARD OF NURSING - PO BOX 83720 - BOISE, ID 83720-0061
(208) 334-3110
APPLICATION FOR ADVANCED PRACTICE PROFESSIONAL NURSE REINSTATEMENT

For Office Use Only

License #_____

APPN #_____

Receipt#_____

Amount _____

Approval

Temp_____

Licensure_____

Check the category for which reinstatement is being made:

☐ Advanced Practice Professional Nurse
- ☐ Certified Nurse-Midwife
- ☐ Clinical Nurse Specialist
- ☐ Nurse Practitioner
- ☐ Registered Nurse Anesthetist

☐ Temporary Licensure

AFFIX A 2″ X 2″

PHOTOGRAPH

HEAD AND SHOULDERS ONLY
Taken within the Year

DO NOT STAPLE

Date of photo_____

Name_____
Last First Middle Maiden

Other names used previously_____

Mailing Address_____
City State Zip Code

Telephone - Home: ( )_____Work: ( ) _____ S.S. No. _____

Birthplace_____Birth Date_____
(City & State)

ADVANCED PRACTICE PROFESSIONAL NURSE CERTIFICATION

APPN Certification*:
Name of certifying organization:_____
Date of original certification:_____Current expiration date:_____

*A notarized copy of your current certificate from a national organization must be attached to the enclosed Affidavit.

EMPLOYMENT INFORMATION

LIST LAST TWO YEARS OF NURSING EMPLOYMENT:

Name & Complete Address of Employer	**Position**	**Employment**	
		From	**To**

If you have not been employed in advanced practice nursing within the last two years, or if there are gaps in employment, please explain. (Supervised practice and a content update may be required if you have not engaged in advanced nursing practice for more than two years.)_____

- over –

ATTESTATION

By signing the notarized affidavit on this application, I hereby attest that I have practiced a minimum of two hundred (200) hours of advanced practice professional nursing practice within the two (2) year period preceding the filing of this application. Please initial that you have read this statement_____.

IT IS THE DUTY OF EACH APPLICANT TO MAKE INQUIRY OF THE INDIVIDUAL LICENSING BOARDS REGARDING THE STATUS OF LICENSURE IN THAT STATE BEFORE RESPONDING TO THE QUESTIONS BELOW. **Ignorance of license status or disciplinary information will not constitute an excuse for incorrect information. In addition, failure to disclose all licenses may result in denial of your application or other appropriate action.**

SCREENING QUESTIONS

PLEASE ANSWER ALL QUESTIONS **(For all "yes" answers, attach a complete explanation including dates, circumstances and supporting documents if necessary.)**

1. Has your nursing license ever been disciplined in any state (e.g., revoked, suspended, placed on probation, formally reprimanded, or otherwise encumbered)? ☐Yes ☐No
2. Is any action pending against your nursing license in any state? ☐Yes ☐No
3. Have you ever had approval to practice in an advanced role denied, limited, suspended, revoked or otherwise disciplined? ☐NA ☐Yes ☐No
4. Have you ever had an application for nursing license denied? ☐Yes ☐No
5. Have you ever been denied admission to take a nursing examination by any state? ☐Yes ☐No
6. Do you have, or have you been diagnosed as having, or have you been treated for having a physical or mental condition, including drug or alcohol addiction during the past five (5) years, which may impair your ability to practice nursing with reasonable skill and safety? ☐Yes ☐No
7. If yes, do you require special accommodations in order to practice? ☐NA ☐Yes ☐No
8. Do you currently have any felony or misdemeanor charges pending against you in any jurisdiction? ☐Yes ☐No
9. Have you ever pled guilty, entered a plea of nolo contendre, been convicted of, or received a withheld judgment for a misdemeanor or felony in any jurisdiction? ☐Yes ☐No

DECLARATION OF RESIDENCE.

I am declaring _____as my primary state of residence. I understand that if I move to Idaho, I must apply for an Idaho license within 30 days of relocating to this state.

THE AFFIDAVIT BELOW MUST BE COMPLETED IN ORDER FOR YOUR APPLICATION TO BE VALID.

AFFIDAVIT

State of _____)
) s.s.
County of _____)

I,_____being duly sworn, declare that I understand the instructions and terms as set forth in this application form, that I am the person referred to in the foregoing application and this affidavit, and that I have personally completed this form, and that the information given in this application is true, correct and complete. I declare that I have no mental or physical disabilities (except as otherwise noted above) that presently interfere with my ability to competently and safely practice nursing and that I have read and understand this affidavit.

_____
Signature of Applicant

On this _____ day of _____, in the year of _____before me _____, notary public, personally appeared _____known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

_____
My Commission expires_____

IDAHO BOARD OF NURSING
ADVANCED PRACTICE PROFESSIONAL NURSE
CONTINUING EDUCATION ACTIVITIES REPORT

FROM_____ TO_____

NAME_____

APPN License number: CNM_____ CNS_____ NP_____ RNA_____

ADDRESS_____

_____

Advanced Practice Professional Nurse License Renewal: Rule 23.01.01.300.03.	RENEWAL OF LICENSURE IS DEPENDENT UPON documentation of 30 contact hours of continuing education during… [the last] two year period
Authorization Renewal: Rule 23.01.01.315.02.b.	RENEWAL OF PRESCRIPTIVE AUTHORITY IS DEPENDENT UPON completion of ten (10) contact hours of approved pharmacology-related continuing education in the twenty-four (24) months immediately preceding application for renewal. Hours may be part of the thirty (30) required hours (above).
DEFINITIONS:	CONTINUING EDUCATION_– consists of planned learning experiences designed to maintain and update knowledge, skills, and attitudes for the enhancement of practice. CONTACT HOURS = equal clock hours.

THIS REPORT MAY BE AUDITED. IF SELECTED FOR AUDIT, YOU MAY BE ASKED TO SUBMIT DOCUMENTATION OF COMPLETION OF INDICATED CONTINUING EDUCATION. (Attach additional pages if necessary.)

DATE	NAME OF PROGRAM	SPONSOR	Contact Hours	Pharmacolgy-Related Hours

AFFIDAVIT ATTESTING TO VALIDITY OF COPY

I hereby certify that the attached is a direct photocopy of:
Please ☒ appropriate box (es).

- ☐ The certificate which shows proof of current licensure as a licensed professional nurse (RN)
- ☐ The certificate which shows advanced practice professional nurse national certification

Total number of documents_____ _____
Signature of Applicant

On this _____ day of _____, in the year of _____, before me _____, a notary public, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

_____
(Notary Seal) Notary Public

_____
My Commission Expires

AFF Rein APPN